Correspondence

The Editorial Board will be pleased to receive and consider for publication correspondence containing information of interest to physicians or commenting on issues of the day. Letters ordinarily should not exceed 600 words, and must be typewritten, double-spaced and submitted in duplicate (the original typescript and one copy). Authors will be given an opportunity to review any substantial editing or abridgment before publication.

Malaria in California

TO THE EDITOR: A 55-year-old married white man, a truck driver from Colton, California, was seen at the Loma Linda University Medical Center emergency room. He had a one-week history of fatigue, drowsiness, malaise, myalgias, polydipsia, evening chills, fevers and profuse diaphoresis, lasting 30 to 45 minutes. Just before coming to the emergency room, he had vomited approximately half a cup of blood. On routine blood count it was found that approximately 75 percent of his red blood cells had *Plasmodium vivax* involvement. This was confirmed on thick smears.

The patient said that he had not left the country except once in 1975, when he traveled to Tijuana, Mexico. He had made one trip to Arkansas in 1979. He could not recall any previous, similar episodes or exposure to malaria. He had not had any transfusions or injections and none of his family had had malaria. He had no other medical problems except for hypertension. He had hauled wine grapes during the summer of 1980 around the Fresno area and had slept in his truck at night. He may have been bitten by mosquitoes any number of times. He was exposed to both migrant workers and the local Punjabi Indian group in that area.

In hospital he was noted to have gross hematuria. Two duodenal ulcers were found on upper gastrointestinal studies. His hemoglobin level on admission had been 9.8 grams per dl; this dropped to 7.0 grams per dl and left upper quadrant pain developed. A computed tomographic scan of the abdomen showed areas of small splenic hematomas and infarction.

This is the first case of endemic malaria reported in the continental United States since 1974, according to the Center for Disease Control in Atlanta. It was fortuitous to find malarial forms on routine blood count because, with the lack of travel outside the United States or exposure through transfusion, the patient's history would have eliminated the suspicion of malaria and delayed the diagnosis. Standard antimalarial therapy was given and the patient made a good response.

With the mobility of western Americans well established, physicians should be suspicious of acute intermittently febrile illness even without a history of travel outside the United States.

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TO THE EDITOR: A 37-day-old infant boy was seen in the Contra Costa County Emergency Room in Martinez, California, on February 26, 1981, because of a cough.

At birth the patient weighed 3.0 kg following an uneventful term pregnancy and was delivered vaginally to an 18-year-old Laotian woman (primipara). The patient's mother had imigrated to the United States the previous May, at about the same time that the patient was conceived. She could recall having several bouts of a febrile illness while living in Laos. She also had spent some time in refugee camps in Thailand and Malaysia before coming to California. There had been no illness throughout the duration of the pregnancy which had been spent in Contra Costa County.

When discharged from hospital on the third day of life, the patient was found to have a smooth, firm liver edge palpable 1.0 cm below the right costal margin. The spleen was not palpable and the rest of the physical examination showed no abnormalities. At five days of age, jaundice developed. Findings on physical examination otherwise were unchanged. The diagnosis of physiologic jaundice was made and the child treated with formula and water supplements to breast feeding. Serum total bilirubin reached a maximum of 10.3 mg per dl with a maximum direct bilirubin of 2.3 mg per dl on day seven of life. Hematocrit at this time was 47 percent. Within the next six days, jaundice resolved totally. Oral candidiasis also developed during the patient's third week of life and was treated with and

responded to administration of nystatin suspension. There had been no travel outside the country.

When seen in the emergency room, the infant weighed 3.4 kg. He was pale and very lethargic. Body temperature was 38.5°C, taken rectally. The liver edge was palpable 2 cm below the right costal margin and the spleen was enlarged to 6 cm below the left costal margin. The rest of the physical examination gave normal findings. Laboratory data included a leukocyte count of 7,900 per cu mm with 19 percent neutrophils, 11 percent band cells, 68 percent lymphocytes and 2 percent monocytes. The hemoglobin measured 7.9 grams per dl, the hemotocrit 21.9 percent, the reticulocyte count was 3.0 percent, and there were 90,000 platelets per cu mm. An estimated 2 percent to 3 percent of the red cells contained malaria parasites which were later identified as *Plasmodium vivax*. Analysis of cerebrospinal fluid and urine gave results within normal limits. Cultures of urine, cerebrospinal fluid and blood were negative.

The patient was admitted to hospital with a diagnosis of congenitally acquired *Plasmodium vivax* malaria. He was treated immediately with chloroquine phosphate, 5 mg base per kg of body weight, by gavage. The same dose was given 6 hours, 24 hours and 48 hours after admission. The patient became afebrile within 36 hours and thick and thin blood smears for malaria were negative within 48 hours. Two weeks after admission, the patient was seen in clinic and was thriving. Smears for malaria were negative and the anemia had improved.

Thick and thin smears of the mother's blood made at the time of diagnosis were negative for malaria parasites. A thin smear made at the time of delivery was reviewed and was also negative. Nevertheless, the mother was treated with both chloroquine and primaquine.

As a result of this experience and with the increasing incidence of congenital and imported cases of malaria,[1-3] we are reminded to consider the diagnosis of malaria in all Southeast Asian children with fever, especially if there is hepatosplenomegaly. We continue to study the problem of screening pregnant women who have lived in or traveled through endemic areas.

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3. Woods WG, Mills E, Ferrieri P: Neonatal malaria due to Plasmodium vivax. J Pediatr 85:669-671, Nov 1974

Still More HAFE

TO THE EDITOR: Your publication of the recent state of the art letter by Drs. Auerbach and Miller on high altitude flatus expulsion (HAFE)[1] demands applause. Certainly, the importance of the syndrome cannot be overstated. While few practitioners of the art and science of medicine will encounter high altitude pulmonary edema (HAPE), many will be forced to deal with the devastating effects of HAFE with victims loudly announcing their need for medical intervention.

Unfortunately, because of psychosocial factors which mitigate against self-designation, the reporting of incidence, frequency and severity of this disorder is entirely inadequate. The resultant medical ignorance, or perhaps even medical neglect, casts a pall over the credibility of the entire medical profession. Without an adequate data base, we in the medical community cannot even begin to explore the anatomy, physiology and appropriate therapy of HAFE. We therefore propose the establishment of an international reporting system for the collection of all data relevant to this and related disorders. The acronym SCHTOOOL seems most appropriate and easily recalled—Society (for the) Collection and Historical Tabulation of Olfactory and Otherwise malOdorous Literature.

In recognition of the pioneering work and perceptual powers of the authors of this landmark report, we urge these physicians to accept the call to become overseers of all information relevant to this vital subject. Whenever possible, a representative aliquot of the pathologic material should be collected and sent to them, and they should be encouraged to do a prospective study.

In addition, the journal must be congratulated for recognizing the importance of this paper and appropriately airing it before an eager audience. Dissertations such as this are a breath of fresh air in a wilderness of largely irrelevant medical eructations.

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